Controlling Health Care Spending:
Options for Utah Policymakers

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JOHNS HOPKINS
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Our Project

Objective: Faculty at Johns Hopkins are working with states to lower health care prices in the private sector

- Analytic component:
  - compare private sector and Medicare prices,
  - explore price variation across services, communities, settings, and consumers
  - examine out-of-network billing
- Policy component:
  - provide examples of strategies employed in other states
  - support development of evidence based legislation

Our Project

Funding: Arnold Foundation

No cost to the state

Timeframe: 3 years (2018-2021)

Faculty: Gerard Anderson, Aditi Sen, Ge Bai, Matt Eisenberg, Amber Willink, Ann Kempski (NCHC)

Current State Engagements

- Delaware
- California
- North Carolina
- Connecticut
- Washington
- Colorado

Problem

Private sector prices are rising twice as fast a public sector prices

Private sector prices are now double public sector prices for hospital and physician services and continuing to increase

Market is not working to control private sector prices

Why are private prices rising faster than public prices?

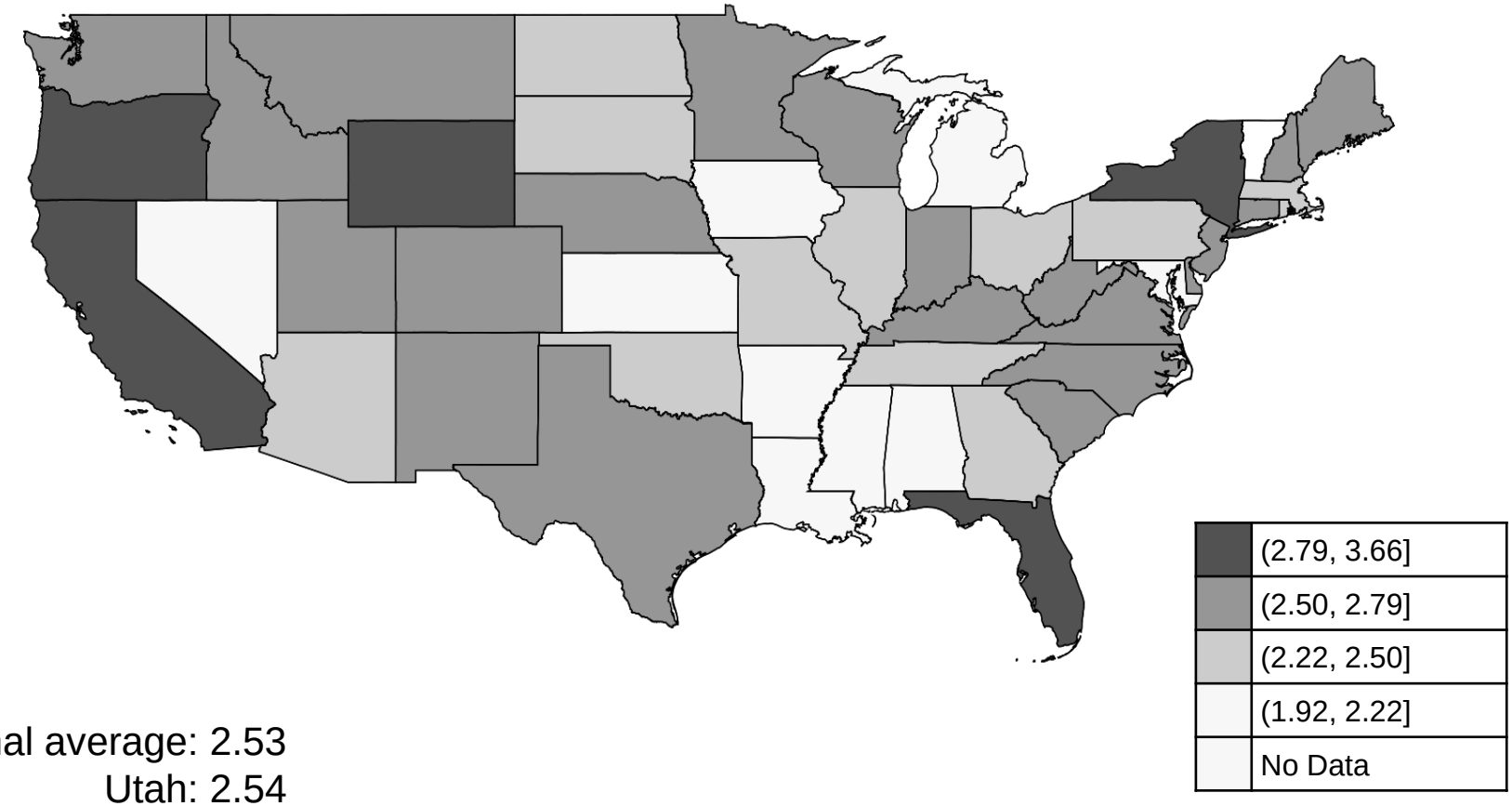
Private prices are driven by market forces and are greatly affected by market competition and consolidation.

In most localities one or two health systems dominate they and are able to determine the prices because the insurer needs them in the network.

Medicare prices account for differences in:

- geography,
- teaching status,
- patient case mix.

Private/Medicare Price Ratio



National average: 2.53
Utah: 2.54

We are Helping States With the Following Policies

- Determination of Out-Of-Network Prices (CA)
- Determination of Prices for State Employees (NC)
- Increasing Price Transparency (CO)
- Increasing Competition (CT)
- Public Option Rural Hospitals and Value-based payments (WA)

Value Based Purchasing

There are many examples of value based purchasing

Many of them have not been able to control spending

One challenge is to develop a definition of value

A second challenge is to get all parties to agree on a definition of value

Value-Based Purchasing in Public Employees' Health Program

Episode-based payment

- Tennessee (46 episodes)
- Washington (1 condition, "centers of excellence")

Population-based payment

- California (CalPERS ACOs shared savings and risk)
- Washington (ACOs for state employees and non-Medicare retirees)

Value-based insurance design

- Tiered network plan for providers (MA, MN)
- Tiered network plan for services (CT)

Value-based Purchasing Statewide

Examples:

- Maryland's All-Payer Global Budgets
- Vermont's All-Payer Accountable Care Organization

Challenges:

- How to define, agree on, and measure value
- How to create strong enough incentives for performance change

Evidence:

- Evaluations of MD's global budgets have mixed results
- VT too early to evaluate

Prices in State Employee Plans

States	Rate-Setting	Details
Montana	234% Medicare	Savings in 2018 estimated at $15.6 million
Oregon	200% Medicare (in-network) 185% (out-of-network)	Starting 2019. Difference in in-network and out-of-network rates to encourage participation. Protections from balance billing patient.
California	CalPERS reference price 5 services	$6 million saved over two years just for hip and knee replacements. Five services include hip and knee replacements, colonoscopies, cataract surgery, and arthroscopy procedures.
North Carolina (in-progress)	182% Medicare	Currently in contracting process with providers.

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